

**Division of Developmental Disabilities  
Office of Quality Improvement  
Day Program Review Tool**

**II INDIVIDUAL FILE REVIEW**

Agency: \_\_\_\_\_  
 Individual: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Site: \_\_\_\_\_  
 Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone: \_\_\_\_\_

Client Initials~						COMMENTS
	Y/N/NA					
Original referral package						
Documentation of disability						
Social history or justification for eligibility						
ABS/behavior checklist						
Verification of referral/non referral to DVRS						
Medical form for adults completed within 1 year						
Individual habilitation plan						
Guardianship document						
Other pertinent: Psychological, Psychiatric, IEP						

<b>Pre-admission documentation</b>						<b>COMMENTS</b>
Pre-admission interview						
Program information sheet: signed, dated by SR and HR						

<b>Temporary, Guest or Respite placement file review</b>						<b>COMMENTS</b>
Medical form for adults						
Emergency card						
Adaptive behavior summary						
Copy of IHP						

**Division of Developmental Disabilities  
Office of Quality Improvement  
Day Program Review Tool**

<b>Transportation sign off signed/dated</b>	<b>Client Initials~</b>							<b>COMMENTS</b>
By legal guardian								
By home representative								

<b>Consents signed/dated</b>								<b>COMMENTS</b>
Emergency treatment								
Photograph and/or interview								

<b>Copy of current IHP</b>								<b>COMMENTS</b>
Dates of completion								
All sections filled/explanation why not filled								
Results of safety analysis								
Goals and Objectives consistent with life plan								
a Goals are positive, attainable & relevant								
b Minimum of 3 objectives for day services								
c Identify levels of support required								
d Identify persons responsible to implement/document								
Copy of previous year IHP in file								

<b>Progress notes</b>								<b>COMMENTS</b>
Monthly for each IHP objective								
Legible								
Dated, month, day, year								
Description of objective or activity								
Signature and title of entry person								

<b>Daily Training Records</b>								<b>COMMENTS</b>
Reflect goals & objectives identified in IHP								
Documentation includes support code & staff initials								

**Division of Developmental Disabilities  
Office of Quality Improvement  
Day Program Review Tool**

<b>Vocational Assessment/Profile (only required if interested in employment)</b>	<b>Client Initials~</b>						<b>COMMENTS</b>
Completed annually							
Attached to IHP							

<b>I.T.N. records (if requested at IHP)</b>							<b>COMMENTS</b>
Consent signed by individual/guardian							
Referral for ITN in file							
ITN assessment:							
a Evaluation completed							
b Recommendations documented							
c Therapist quarterly reports							
d Therapist progress notes following each visit							

Behavior Management Plan							COMMENTS
Copy attached to IHP							
Documentation of approval process							
Documentation of an annual review							
Data collection documentation							
Progress notes							
a Dated/month, day & year							
b Legible							
c Current							
d Summarizes progress or lack of from data collection							
e Signature & title of entering person							

Comments:

---



---



---



---

**Division of Developmental Disabilities  
Office of Quality Improvement  
Day Program Review Tool**

<b>Medical form for adults</b>	<b>Client Initials~</b>						<b>COMMENTS</b>
Current and previous year on file							
All sections completed							
Date of last tetanus injection							
Mantoux test date and results							
Tests, labs, and consults results noted							
Signed and dated by physician							

<b>Recommendations from medical</b>							<b>COMMENTS</b>
Orthopedic supports							
Dietary or texture requirements (script needs to be present)							
Feeding techniques/needs							
a Supervision requirement							
b Adaptive equip/assistive devices							
c Positioning							
Eyeglasses							
Copy of prescriptions for medications dispensed at program							

<b>Seizure report</b>							<b>COMMENTS</b>
Completed for each occurrence							

<b>Unusual incident reports</b>							<b>COMMENTS</b>
Initial report completed accurately							
Investigation completed (if required)							
Follow-ups completed as required							
Recommendations from investigation implemented							

**Division of Developmental Disabilities  
Office of Quality Improvement  
Day Program Review Tool**

<b>Medication Records</b>	<b>Client Initials~</b>						<b>COMMENTS</b>
Medication Administration Record							
a All sections completed							
b Initials and appropriate code entered daily							
c Prescription PRNs documented on front & back							
d Errors circled in red, and documented on back							
e UIR coordinating to medication error completed, if needed							
Copies of all prescriptions dispensed at program							
a COPY, written across top of prescription in red ink							
b Prescriptions are current/date ordered within 1 year							
c Prescriptions match the MAR							
Copies for "OTC medications as needed"							
a Completed by physician, dated & signed within one year							
b OTC on front & back of Medication form if administered							

<b>Safety analysis for non-staffed activities</b>							<b>COMMENTS</b>
All sections completed							
Results noted on IHP							

<b>Volunteer opportunities documented</b>							<b>COMMENTS</b>
Name, address, & phone number of volunteer site							
Contact person at volunteer's site							
Volunteer job description							
Start date							
Scheduled hours							

<b>Payroll related forms</b>							<b>COMMENTS</b>
W-2 form present							
Compensation records agree with State/Fed laws DC # 26							

# Division of Developmental Disabilities

## Office of Quality Improvement

### Day Program Review Tool

Notification of movement forms (effective 7/02)						COMMENTS
Completed for admission to program						
Admitted 10 working day's post receipt referral package						
Completed for transfers/discharges						

Correspondence	Client Initials~					COMMENTS
Maintained in individual's file						

Annual Reviews						COMMENTS
Rights of the developmentally disabled						
Agency's emergency procedures						

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Revised 8/5/03